Abstratct 0456 – Table: Reperfusion rates, types, timing and adjunctive medications among the age groups

	Age groups				
	<65 years n=3476	**65-74 years n=1238**	**75-84 years n=1147**	**≥85 years n=308**	**P-value**
No reperfusion, n (%)	3.8	5.6	8.0	13.6	<0.001
Fibrinolysis, n (%)	1853 (53.3)	593 (47.9)	449 (39.2)	87 (28.3)	<0.001
Primary PCI, n (%)	1492 (42.9)	576 (46.5)	606 (52.8)	179 (58.1)	<0.001
Delay (first medical contact to PPCI), median (IQR), min	80 (58-123)	85 (60-125)	85 (64-130)	84 (60-124)	0.1
Bivalirudin*, n/N (%)	81/1197 (6.8)	30/429 (7.0)	48/373 (12.9)	28/121(23.1)	<0.001
GPI*, n/N (%)	1375/2695 (51.0)	493/963 (51.2)	435/879 (49.5)	85/222 (38.3)	0.003

* Calculated among patients undergoing a coronarography. Bivalirudin has been used since 2008.

0189

Reperfusion strategy in renal dysfunction patients presenting with STEMI

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Background Patients with renal insufficiency experience worse prognosis after STEMI.

Aim of the study to compare primary PCI (PPCI) and thrombolysis results as well as in-hospital mortality after successful reperfusion between patients with or without renal dysfunction (RD).

Methods From January 1995 to October 2014, 1588 patients admitted for STEMI were enrolled in our registry. Two reperfusion groups were identified: PPCI (315 patients) and thrombolysis (379 patients). We compared the group of RD patients (RD+) and normal renal function patients (RD). Our main endpoints were: (1) The success of reperfusion and (2) the in-hospital mortality.

Results Ninety patients (13%) had RD, 50% of which underwent PPCI, and 50% received thrombolytics. In the PPCI group, although TIMI flow was similar before angioplasty (p=0.82), TIMI III flow restoration was significantly lower in the RD+ group (78.6% vs 91.8%, p=0.013).

Suboptimal result was also higher in the RD+ group (13.6% vs 2.7%, p<0.001), but ST regression after TIMI III achievement was similar in the 2 groups (p=0.43) reflecting probably no microvascular damage.

In the thrombolysis group, successful reperfusion was also significantly lower when RD exists (58% vs 74%, p=0.03), but RD was not an independent predictor of thrombolysis failure. RD was an independent mortality predictor either after PPCI or thrombolysis (respectively p=0.014, OR=4.39 and p=0.006, OR=4.93).

After successful reperfusion, in-hospital mortality was higher among RD+ patients in the PPCI group (33.3% vs 4.3%, p<0.001), whereas it was similar after successful thrombolysis (p=0.42).

In-hospital mortality was higher in RD+ patients when mechanically reperfused (40% vs 18.2%, p=0.024), whereas no significant difference was found among RD- patients (p=0.75).

Conclusion RD reduces PPCI success.

Although RD was an independent mortality predictor regardless of the reperfusion strategy, prognosis was worse in RD group only after successful PPCI.

The author hereby declares no conflict of interest

0253

Prognostic impact of interventional approach in non-ST segment elevation acute coronary syndrome in very elderly Algerian patients

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Introduction and objectives In moderate or high risk non-ST segment elevation acute coronary syndrome, clinical practice guidelines recommend a coronary angiography with intent to revascularize. However, evidence to support this recommendation in very elderly patients is poor.

Methods All patients over 85 years old (military hospitals of Algeria) admitted between 2006 and 2014 with a diagnosis of non-ST segment elevation acute coronary syndrome were retrospectively included. Using a propensity score, patients undergoing the interventional approach and those undergoing conservative management were matched and compared for survival and survival without ischemic events.

Results We included 167 consecutive patients with a mean age of 88 years (range: 85 to 101). Those in the interventional approach group (n=67) were younger, with a higher proportion of males and less comorbidity, less cognitive impairment and lower troponin I levels compared with patients in the conservative management group (n=100).

We matched 60patients from the interventional approach group and 60 from the conservative management group using propensity score. In the matched patients, the interventional approach group exhibited better survival (log rank 4.24; P=0.039) and better survival free of ischemic events (log rank 8.63; P=0.003) at the 3-year follow-up. In the whole population, adjusted for propensity score quintiles, the interventional approach group had lower mortality (hazard ratio 0.52; 95% confidence interval: 0.32-0.85) and a better survival free of ischemic events (hazard ratio 0.48; 95% confidence interval: 0.32-0.74).

Conclusions Nearly all the very elderly patients admitted with non-ST segment elevation acute coronary syndrome were of moderate or high risk. In these patients, the interventional approach was associated with overall better survival and better survival free of ischemic events.

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0043

FFR Gray zone and clinical outcome

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Aims Fractional flow reserve (FFR) invasively assesses the ischemic potential of coronary stenosis.FFR value of 0.75 has been referred to the ischemic FFR threshold validated against non-invasive functional testing; while an FFR value of 0.80 has guided clinical decision making in multicenter clinical trials. Revascularization in case of FFR values in the gray zone between 0.75-0.80 is still debatable. We investigated the clinical outcome of patients with an isolated stenosis and FFR value in the gray zone.

Methods From 1997 to 2013, we retrospectively included all patients with single segment disease at coronary angiography and FFR between 0.70-0.85. We defined the following FFR groups: a) 0.70-0.75; b) 0.76-0.80 (gray zone);